

Group Dental Insurance Plan Enrollment Form

Underwritten by The United States Life Insurance Company in the City of New York
Executive Office: P.O. Box 667, Wilmington, Delaware 19899-9853 (302) 594-2000



1. Select the type of plan and billing frequency you prefer.
2. Complete the personal information requested.
3. Print, sign, date and return enrollment form along with payment to: ASRT Insurance Program Administrator
159 East County Line Road
Hatboro, PA 19040-9635

1. BENEFIT PLAN SELECTION

Choose coverage for: Member Only Member & Spouse Member & Dependent Child(ren)
 Family Coverage (including Member, Spouse and Child(ren))

2. PERSONAL INFORMATION (PLEASE PRINT)

Name: _____ Membership #: _____
Address 1: _____ Address 2: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email address: _____
Social Security #: _____ Sex: Male Female
Date of Birth: _____ Place of Birth: _____

Please complete the following if you are enrolling for Family Coverage

Name	Date of Birth	Social Security Number
SPOUSE		
CHILD		
CHILD		

* Children must be unmarried and under age 19; age 25 if a full time student (subject to state variations).
Attach a separate piece of paper, if you are enrolling more than 2 children.

3. BILLING OPTION SELECTION

OPTION 1: Electronic Funds Transfer Monthly Quarterly Semi-Annual Annual

Authorization for Electronic Funds Transfer

I request and authorize Affinity Insurance Services, Inc. (LifeHealth) to make withdrawals based on my selected payment method above against the account specified on the attached voided check or savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. **In order to process your electronic payment, both the Account # and Bank Routing # must both appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage immediately if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

X _____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

OPTION 2: Direct Bill Quarterly Semi-Annual Annual (Make check payable to: Affinity Insurance Services, Inc.)

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under the ASRT Group Dental Insurance Plan. I have read and understand the conditions and exclusions of the program. I understand that the insurance applied for shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first premium payment.

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud language varies by state.)

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____
(If enrolling)

G-19477

Please see next page for compensation disclosure information

Group Policy No: V-610,210
AG8662

Please complete the enrollment form and return it with payment to:

ASRT Insurance Program Administrator
159 East County Line Road
Hatboro, PA 19040-9635

Don't let an unanswered question delay your enrollment.

Call toll free: 1-877-212-8334
www.asrtinsurance.com

COMPENSATION and OTHER DISCLOSURE INFORMATION

Life & Health, a division of Affinity Insurance Services, Inc., exclusively offers the Group Dental Insurance Program as an agent of The United States Life Insurance Company in the City of New York and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 17% of your paid premium. In addition, Affinity may charge a fee for administrative services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise. Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at http://www.aon.com/market_relationships for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit http://www.aon.com/market_relationships for more detail on these agreements.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility.

The ASRT Insurance Program is administered by Aon Affinity, a division of Affinity Insurance Services, Inc.; in CA, MN & OK, a division of AIS Affinity Insurance Agency, Inc.; and in NY a division of AIS Affinity Insurance Agency. CA License #0795465. AR License #244489.